DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495146	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/02/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT HARRISONBURG	**94 SOUTH AVENUE HARRISONBURG, VA 22801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 35701 TYPE OF STRUCTURE: One (1) story, Type II (111) non-combustible construction with four (4) smoke compartments and a complete automatic (wet) sprinkler system. An unannounced Life Safety Code survey was conducted on 02/02/2017 in accordance with 42 Code of Federal Regulations, Part 483.150 and 410 to 480: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing Regulations. The facility was found to be not in compliance with the Requirements for Participation for Medicare and Medicaid. The Findings that follow demonstrate noncompliance with title 42 Code of Regulations. Part 483.150 and 410 to 480 (Life safety from Fire).	K 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907	
K 222 SS=E	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the	K 222	**K-222 NFPA 101 Egress Doors** **Corrective action taken for identified problem:** A-wing exit door by room 30 and B-Wing exit door by room 31 Magnetic locking systems were inspected and found to be operating properly. **How facility will identify similar occurrences of the problem:** The other exit doors were tested and were functioning properly. **Identify measures/systemic changes to ensure deficient practice will not recur:** The exit doors are on the preventive maintenance system to be inspected for proper function weekly times 4 weeks including routine exercise of the door and magnetic locking system by the Director of Facility Services or designee	**3/10/17**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 2/17/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 222	Continued From page 1 safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This Standard is not met as evidenced by: Surveyor: 35701	K 222	**K-222 Continued:** **Indicate how the facility will monitor its performance:** The Director of Facility Services or designee will report findings to the monthly Quality Assurance committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	

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K 222	Continued From page 2 Based on observation, the facility failed to maintain egress doors. This has the potential to affect all residents. The Findings include: It was observed on 02/02/2017 at 1:35 PM, the delayed egress exit doors located in the A wing near room 30 did not open after the 15 second delay. It was observed on 02/02/2017 at 2:20 PM, the delayed egress exit doors located in the B wing near room 31 did not open after the 15 second delay.	K 222 **K - 231**	**K-231 NFPA 101 Means of Egress Capacity** **Corrective action taken for identified problem:** The hall way has been cleared of all furniture. **How facility will identify similar occurrences of the problem:** The other hallways have been inspected for obstructions and were found to be appropriate. **Identify measures/systemic changes to ensure deficient practice will not recur:** The Director of Facility Services will monitor the placement of any new furniture weekly to ensure the hallways have a minimum clearance of 6 feet. **Indicate how the facility will monitor its performance:** The Director of Facility Services or designee will report findings to the monthly Quality Assurance committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	**3/10/17**
K 231 SS=D	NFPA 101 Means of Egress Capacity Means of Egress Capacity The capacity of required means of egress is in accordance with 7.3. 18.2.3.1, 19.2.3.1 This Standard is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain the egress capacity. This has the potential to affect all residents. The Findings include: It was observed on 02/02/2017 at 2:28 PM, the wooden bench seats was not fixed to the wall or floor and reduced the egress width below 6 feet.			
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353	**K-353 NFPA 101 Sprinkler System** **Corrective action taken for identified problem:** The patient equipment has been removed; the sprinkler head has been cleaned in Laundry; the escutcheon plate has been replaced in the Linen /	**3/10/17**

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K 353	Continued From page 3 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Standard is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain fire protection equipment. This has the potential to affect all residents. The Findings include: It was observed on 02/02/2017 at 12:49 PM, access to the sprinkler control valves was obstructed by the storage of 46 E cylinders of oxygen and patient equipment. It was observed on 02/02/2017 at 12:59 PM, an escutcheon plate was missing in the soiled linen/laundry room. It was observed on 02/02/2017 at 1:00 PM, sprinkler heads located in the laundry/dryer area was loaded.	K 353	**K-353 Continued:** laundry; and the storage of oxygen has been removed and relocated. **How facility will identify similar occurrences of the problem:** The current sprinkler heads have been inspected for dust and dirt as well as appropriate escutcheon is in place. **Identify measures/systemic changes to ensure deficient practice will not recur:** The Director of Facility Services or designee will monitor the sprinkler control valve weekly to insure free from obstruction of any kind; the sprinkler heads are part of the preventive maintenance program to be inspected monthly by the director of facility services or designee for any maintenance issue associated and record in Monthly preventive maintenance program. **Indicate how the facility will monitor its performance:** The Director of Facility Services or designee will report findings to the monthly Quality Assurance committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	
K 355 SS=D	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire	K 355	**K-355 NFPA 101 Portable Fire Extinguisher** **Corrective action taken for identified problem:** The portable Fire extinguisher in the sprinkler control valve room has been freed of any obstruction.	**3/10/17**

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K 355	Continued From page 4 Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This Standard is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain portable fire extinguishers. This has the potential to affect one storage area. The Findings include: It was observed on 02/02/2017 at 12:50 PM, the portable fire extinguisher located in the sprinkler control valve room was obstructed by gypsum board.	K 355	**K-355 Continued:** **How facility will identify similar occurrences of the problem:** The current portable Fire Extinguishers have been inspected and have been found to be free of any obstruction. **Identify measures/systemic changes to ensure deficient practice will not recur:** The Director of Facility Services or designee will inspect the portable Fire Extinguishers weekly times 4 weeks for obstructions Correcting immediately and record findings in Monthly preventive maintenance program any . **Indicate how the facility will monitor its performance:** The Director of Facility Services or designee will report findings of the Preventive maintenance program to the monthly Quality Assurance committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	
K 372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This Standard is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain the smoke barrier. This has the potential to affect one smoke compartment. The Findings include: It was observed on 02/02/2017 at 2:02 PM, an	K - 372	**K-372 NFPA 101 Subdivision of Building Spaces-Smoke Barrier** **Corrective action taken for identified problem:** The penetration caused by the data cables have been sealed **How facility will identify similar occurrences of the problem:** The smoke barrier throughout the facility has been inspected and where identified the unsealed penetrations have been sealed.	3/10/17

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K 372	Continued From page 5 unsealed penetration in the smoke barrier created by the data cables located in the B wing near the beauty shop.	K 372	**K-372 Continued:** **Identify measures/systemic changes to ensure deficient practice will not recur:** The Director of Facility Services or designee will inspect any newly added data drops to ensure they have been sealed properly after installation going forward. **Indicate how the facility will monitor its performance:** The Director of Facility Services or designee will report findings of any newly found penetrations to the monthly Quality Assurance committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	
K 511 SS=E	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This Standard is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain electrical wiring and equipment. This has the potential to affect 3 smoke compartment. The Findings include: It was observed on 02/02/2017 at 12:53 PM, a junction box located in the maintenance shop was missing a cover. It was observed on 02/02/2017 at 1:27 PM, a junction box located above ceiling near the smoke doors and room 21 was missing a cover. It was observed on 02/02/2017 at 1:50 PM, a junction box located above ceiling at the smoke alarm near room 1 was missing a cover. It was observed on 02/02/2017 at 1:53 PM, a junction box located above ceiling near the conference room located in the main corridor was	K - 511	**K-511 NFPA 101 Utilities – Gas and Electric** **Corrective action taken for identified problem:** The missing Junction box covers have been replaced in the maintenance office, above the ceiling by room 21, room 1, and conference room. **How facility will identify similar occurrences of the problem:** The Director of Facility Services or designee has inspected areas above the ceiling on each hallway to determine if additional covers are needed and were identified as being needed, they have been replaced.	**3/10/17**

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K 511	Continued From page 6 missing a cover.	K 511	**K-511 Continued:** **Identify measures/systemic changes to ensure deficient practice will not recur:** The Director of Facility Services or designee will inspect any electrical work completed above the ceiling to ensure compliance with this regulation before the contractor leaves the facility. **Indicate how the facility will monitor its performance:** The Director of Facility Services or designee will report findings to the monthly Quality Assurance committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	
K 711 SS=D	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This Standard is not met as evidenced by: Surveyor: 35701 Based on record review and interview, the facility failed to maintain the emergency evacuation plan. This has the potential to affect all residents. The Findings include: A review of records on 02/02/2017 at 12:30 PM revealed dialing 911 was not indicated in the plans A review of records on 02/02/2017 at 12:30 PM revealed pulling the manual pull stations was not part of activating the fire alarm system. A review of records on 02/02/2017 at 12:30 PM revealed the assembly areas was not identified on the evacuation plans. A review of records on 02/02/2017 at 12:31 PM revealed the emergency contact list was not updated to reflect current staff.	**K - 711**	**K-711 NFPA 101 Evacuation and Relocation Plan** **Corrective action taken for identified problem:** The emergency evacuation plan has been updated to include the calling of 911, pulling of the manual fire station as part of the activation of the Fire alarm when necessary. The Emergency contact list has been updated to reflect current staff and assembly stations have been established and identified on the facility Evacuation Plan. **How facility will identify similar occurrences of the problem:** The Director of Facility Services or designee has included the items added	**3/10/17**

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K 711	Continued From page 7 An interview with the interim administrator on 02/02/2017 at 12:31 PM confirmed the emergency contact list was not current to reflect current staff information. An interview with the interim administrator on 02/02/2017 at 10:50 AM revealed 103 patients currently are receiving care at the facility. A review of records on 02/02/2017 at 12:33 PM revealed the facility has the capacity to relocate 60 patients to Avante facilities located in Lynchburg, Waynesboro and Roanoke. An interview with the interim administrator at 12:35 PM revealed no formal agreement was established with any other facility to assist with the relocation of the remaining 43 patients.	K 711	**K-711 Continued:** above to the evacuation plan to the monthly training during established Fire drills. This will be recorded on the monthly fire drill signature sheet. **Identify measures/systemic changes to ensure deficient practice will not recur:** The Director of Facility Services or designee will conduct an in-service for current staff on the changes to the Evacuation plan as outlined above and include this during orientation of new staff, and verbally quiz staff during fire drills to determine knowledge and where indicated re-educate the staff as necessary. **Indicate how the facility will monitor its performance:** The Director of Facility Services or designee will report findings to the monthly Quality Assurance committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	
K 712 SS=D	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This Standard is not met as evidenced by: Surveyor: 35701 Based on record review and interview, the facility failed to conduct fire drills. This has the potential	**K - 712**	**K-712 NFPA 101 Fire Drills** **Corrective action taken for identified problem:** We educated 3rd shift staff on missing Fire Drill and in-serviced Fire Drill protocol **How facility will identify similar occurrences of the problem:** Review of the Life Safety Fire Drill log did not show any other missing drills.	**3/10/17**

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K 712	Continued From page 8 to affect all residents. A review of records on 02/02/2017 at 11:51 AM revealed that no fire drill was conducted in the 4th quarter for the third shift. An interview with the interim administrator on 02/02/2017 at 11:52 confirmed that no fire drill was conducted during the 4th quarter for the third shift.	K 712	**K-712 Continued:** The Director of Facility Services or designee will conduct the appropriate Fire drills quarterly and record in the Life Safety Log Book. **Identify measures/systemic changes to ensure deficient practice will not recur:** The Administrator or designee will review the Life Safety Log Book monthly to determine compliance with this regulation. **Indicate how the facility will monitor its performance:** The Administrator or designee will report the compliance to the monthly Quality Assurance committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	
K 754 SS=D	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This Standard is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain trash collection receptacles. This has the potential to affect one smoke compartment. The Findings include: It was observed on 02/02/2017 at 1:29 PM, the trash receptacle located in the soiled utility room	**K - 754**	**K-754 NFPA 101 Soiled Linen and Trash Containers** **Corrective action taken for identified problem:** The trash receptacles in the soiled linen rooms have been inspected by the Housekeeping Manager or designee and are being emptied more frequently. **How facility will identify similar occurrences of the problem:** The Housekeeping Manager or designee will monitor daily the trash containers in the soiled Linen rooms to ensure they are emptied timely.	**3/10/17**

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K 754	Continued From page 9 was overfilled with waste material.	K 754	**K-754 Continued:** **Identify measures/systemic changes to ensure deficient practice will not recur:** The Housekeeping Manager or designee will schedule trash removal times and when necessary additional times as necessary to avoid overfilling of the containers. This will be documented 4 times weekly times 4 weeks reporting findings to the Unit Managers for correction as necessary. **Indicate how the facility will monitor its performance:** The Housekeeping Manager or designee will report findings monthly to the Quality Assurance committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	
K 901 SS=D	NFPA 101 Fundamentals - Building System Categories Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This Standard is not met as evidenced by: Surveyor: 35701 Based on interview and review of records, the facility failed to conduct a risk assessment. This has the potential to affect all residents. The Findings include: A review of records on 02/02/2017 at 3:00 PM revealed the risk assessment was not complete. An interview with the interim administrator on 02/02/2017 at 3:03 PM confirmed the risk assessment was being conducted but not complete.	K - 901	**K-901 NFPA 101 Fundamentals – Building System Categories** **Corrective action taken for identified problem:** The Risk Assessment has been completed to the best of our knowledge. **How facility will identify similar occurrences of the problem:** The Administrator or designee will review the Risk Assessment quarterly to make revisions as we learn more about this process.	**3/10/17**
K 906 SS=D	NFPA 101 Gas and Vacuum Piped Systems - Central Supply Gas and Vacuum Piped Systems - Central Supply System Operations Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495146	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT HARRISONBURG	94 SOUTH AVENUE HARRISONBURG, VA 22801

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K 906	Continued From page 10 flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130 degrees Fahrenheit, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20 degrees Fahrenheit. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99) This Standard is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to store compress gas cylinders in accordance with the Life Safety Code 2012 and NFPA 99. This has the potential to affect one smoke compartment. The Findings include: It was observed on 02/02/2017 at 12:47 PM, a helium compressed gas cylinder stored in the sprinkler control valve room was not secured. It was observed on 02/02/2017 at 12:47 PM, 46 E cylinders of oxygen was being stored in the sprinkler control valve room. Observation of the sprinkler control valve room revealed the room is sectioned off by partial walls that separate the maintenance shop and janitorial supplies. The partial walls are not constucted with a 1 hour	K - 906	**K-901 Continued:** **Identify measures/systemic changes to ensure deficient practice will not recur:** This being a newly required Risk Assessment, by CMS, is a work in progress and will be modified by the Administrator or Designee as new directions are received in the interpretation of the regulation as it affects the Risk Assessment. **Indicate how the facility will monitor its performance:** The Administrator or designee will report modifications monthly to the Quality Assurance committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee. **K-906 NFPA 101 Fundamentals – Building System Categories** **Corrective action taken for identified problem:** The Helium Compressed gas cylinder has been secured to the wall. **How facility will identify similar occurrences of the problem:** The Director of Facility Services or designee has rounded through the facility to determine if there are other similar issues and none were found. **Identify measures/systemic changes to ensure deficient practice will not recur:**	3/10/17

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AVANTE AT HARRISONBURG	**94 SOUTH AVENUE HARRISONBURG, VA 22801**

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K 906	Continued From page 11 minimum rating for separation.	K 906	**K-906 Continued:** This Director of Facility Services or Designee will monitor the Helium Cylinder for compliance by observing the cylinder at least 4 times a week for 4 weeks to ensure it is secured properly. **Indicate how the facility will monitor its performance:** The Director of Facility Services or designee will report non-compliance monthly to the Quality Assurance committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	
K 918 SS=D	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This Standard is not met as evidenced by: Surveyor: 35701 Based on record review, the facility failed to	K - 918	**K-918 NFPA 101 Electrical System – Essential Electric System** **Corrective action taken for identified problem:** The monthly generator recordings will reflect documentation in kW. **How facility will identify similar occurrences of the problem:** There is only one generator so there are no other similar occurrences. **Identify measures/systemic changes to ensure deficient practice will not recur:** This Director of Facility Services or Designee will document the output of the generator in kW as outlined, recording the kw output in the monthly log for the load test of the generator. **Indicate how the facility will monitor its performance:**	**3/10/17**

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K 918	Continued From page 12 maintain the generator. This has the potential to affect all residents. The Findings Include: A review of records on 02/02/2017 at 11:59 revealed the generator monthly recordings are not being documented in kW.	K 918	**K-918 Continued:** The Director of Facility Services or designee will review monthly log reporting any non-compliance monthly to the Quality Assurance committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	
K 920 SS=D	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This Standard is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain electrical equipment. This has the potential to affect 3 smoke compartments.	K 920	**K-920 NFPA 101 Electrical Equipment – Power Cords** **Corrective action taken for identified problem:** The multiple plug adapter in the mechanical room has been removed. The power strips in rooms 12, 7 and therapy gym have been removed **How facility will identify similar occurrences of the problem:** The Director of Facility Services or designee has rounded throughout the facility to identify any additional Multi plug adapters and power strips. Where any were identified they were removed. **Identify measures/systemic changes to ensure deficient practice will not recur:** This Director of Facility Services or Designee will weekly time 4 weeks round through facility to determine compliance, when necessary remove	3/10/17

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K 920	Continued From page 13 The Findings include: It was observed on 02/02/2017 at 1:12 PM, an unapproved multiplug adapter was installed in the mechanical/electrical room to the right of the entry door. It was observed on 02/02/2017 at 1:40 PM, a power strip located in room 12 connected to the television was not listed as UL 1363. It was observed on 02/02/2017 at 1:57 PM, a power strip located in the rehabilitation gym was not listed as UL 1363A or UL 60601-1. It was observed on 02/02/2017 at 2:05 PM, a power strip located in room 7 on top of the wardrobe was not listed as UL 1363.	K 920	**K-920 Continued:** such devices. Any device findings will be reported to the Administrator for follow-up. **Indicate how the facility will monitor its performance:** The Director of Facility Services or designee will report findings of non-compliance monthly to the Quality Assurance committee and then randomly or as needed based on the recommendations of the Quality Assurance Committee.	